NEW BRAUNFELS BRACES

PATIENT INFORMATION

NAME: _____ PREFERRED NAME: _____

BIRTHDATE: _____ AGE: _____ SSN: _____ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ ZIP: _____

CELL PHONE: _____ EMAIL: _____

SCHOOL: _____ GRADE: _____

DENTIST: _____ DATE OF LAST VISIT: _____

SIBLINGS: (Name & DOB) _____

HAS THE PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? _____

PARENT/GUARDIAN 1 INFORMATION - Financially Responsible Party? ☐ YES ☐ NO

NAME: _____ EMAIL: _____

HOME ADDRESS: _____ # OF YEARS @ ADDRESS: _____

PHONE: (cell) _____ (work) _____ (home) _____

EMPLOYER: _____ # OF YEARS: _____ OCCUPATION: _____

BIRTHDATE: _____ SSN: _____

PARENT/GUARDIAN 2 INFORMATION - Financially Responsible Party? ☐ YES ☐ NO

NAME: _____ EMAIL: _____

HOME ADDRESS: _____ # OF YEARS @ ADDRESS: _____

PHONE: (cell) _____ (work) _____ (home) _____

EMPLOYER: _____ # OF YEARS: _____ OCCUPATION: _____

BIRTHDATE: _____ SSN: _____

INSURANCE INFORMATION

INSURED NAME: _____ BIRTHDATE: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____ INSURED ADDRESS: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

INS. ID#: _____ GROUP#: _____ INS. PHONE#: _____

CLAIMS ADDRESS: _____

SECONDARY INSURANCE INFORMATION (if applicable)

INSURED NAME: _____ BIRTHDATE: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____ INSURED ADDRESS: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

INS. ID#: _____ GROUP#: _____ INS. PHONE#: _____

CLAIMS ADDRESS: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

ADDITIONAL INFORMATION

WHAT IS YOUR CHIEF CONCERN? _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Retention of Documents Relating to Patient Care. By signing this, you understand and agree that it is our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

NAME _____ **SIGNATURE** _____ **DATE** _____

PATIENT NAME:_____

DENTAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

☐ Blisters on lips/mouth
☐ Broken fillings
☐ Burning sensation, tongue
☐ Chews on tongue
☐ Dry mouth
☐ Extracted teeth
☐ Finger/thumb habits
☐ Food trapped between teeth
☐ Grinding teeth
☐ Gums bleeding
☐ Gums sore/swollen
☐ Injuries to teeth/jaw
☐ Injuries to face/head
☐ Jaw clicking/popping
☐ Jaw locking open/closed
☐ Jaw pain/tenderness
☐ Jaw surgery
☐ Lip/cheek biting
☐ Loose teeth (other than baby teeth)
☐ Mouth breathing
☐ Mouth pain when brushing
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Periodontal surgery
☐ Sensitivity to hot or cold
☐ Sensitivity to sweets
☐ Sensitivity to pressure
☐ Sores/growths in mouth
☐ Speech problems
☐ Tongue thrust

HOW OFTEN DOES THE PATIENT BRUSH? _____ FLOSS? _____

ADDITIONAL COMMENTS: _____

MEDICAL HISTORY

CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:

☐ AIDS
☐ Anem
☐ Arthritis
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma
☐ Back problems
☐ Blood diseases
☐ Bone disorders
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone treatment
☐ Coughing - persistent
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
☐ Hepatitis
☐ High blood pressure
☐ HIV Positive
☐ Kidney disease
☐ Liver disease
☐ Mitral valve prolapse
☐ Nervous system problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation treatment
☐ Respiratory disease
☐ Scarlet fever
☐ Shortness of breath
☐ Stroke
☐ Stomach ulcers
☐ Swelling of feet
☐ Thyroid problems
☐ Tobacco habit
☐ Tonsillitis
☐ Tonsils removed
☐ Tuberculosis
☐ Urinary problems

☐ Other (not listed) _____

FEMALES ONLY IS IT POSSIBLE THE PATIENT IS PREGNANT? ☐ YES ☐ NO

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

FOR WHAT CONDITION? _____

PHYSICIAN'S NAME: _____ PHONE #: _____

MEDICATIONS:
Please list **ANY & ALL** medications the patient is currently taking:

_____

_____

_____

ALLERGIES:
Please list **ANY & ALL** known allergies you are aware of (EXAMPLE(S): Latex, Metal, Medications):

_____

IS THE PATIENT CURRENTLY TAKING OR HAS TAKEN ANY BONE DENSITY MEDICATIONS? ☐ YES ☐ NO
(Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment. It is my responsibility to inform this office of any changes in my child's personal information or health status. I will not hold this office, our doctors or our staff responsible for any errors or omissions that I have made in the completion of this form.

NAME _____ **SIGNATURE** _____ **DATE** _____

NEW BRAUNFELS BRACES

HIPAA FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPM"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

May we phone/text/email you regarding your appointment?	**YES**	**NO**
May we send e statements in regards to your account?	**YES**	**NO**
May we leave a message on your answering machine or voicemail?	**YES**	**NO**
May we discuss your medical condition with any member of your family?	**YES**	**NO**

If **YES**, please name the members allowed:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HIPAA Privacy

I, _____ (print name) have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

NEW BRAUNFELS BRACES

NOTICE OF FILMING AND PHOTOGRAPHY

Patient Name: _____

When you enter New Braunfels Braces (NBB) you are entering an area where photography, audio, and video recording may occur.

By entering the premises, you consent to interview(s), photography, audio recording, video recording and its/their release, publication, exhibition, or reproduction to be used for news, webcasts, promotional purposes, telecasts, advertising, inclusion on websites, social media, or any other purpose by NBB and its affiliates and representatives. Images, photos and/or videos may be used to promote similar NBB events in the future, highlight the event and exhibit the capabilities of NBB. You release NBB, its officers and employees, and each and all persons involved from any liability connected with the taking, recording, digitizing, or publication and use of interviews, photographs, computer images, video and/or sound recordings.

By entering the New Braunfels Braces (NBB) premises, you waive all rights you may have to any claims for payment or royalties in connection with any use, exhibition, streaming, webcasting, televising, or other publication of these materials, regardless of the purpose or sponsoring of such use, exhibiting, broadcasting, webcasting, or other publication irrespective of whether a fee for admission or sponsorship is charged.

You also waive any right to inspect or approve any photo, video, or audio recording taken by NBB or the person or entity designated to do so by NBB. You have been fully informed of your consent, waiver of liability, and release before entering the premises.

Signature: _____ Date: _____

(parent or guardian if minor)

Signature: _____ Date: _____